(5) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

B. Closure rate adjustment calculation. The Department will calculate the planned closure rate adjustment according to the following:

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the facility or facilities receiving the planned closure rate adjustment are identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

C. A planned closure rate adjustment is effective on the first day of the month following completion of closure of a facility designated for closure in the application and becomes part of the facility's total operating payment rate.

D. A facility or facilities paid pursuant to this Attachment with a closure plan may assign a closure rate adjustment to another facility or facilities that are not closing or, in the case of partial closure, to the facility undertaking the partial closure. A facility may also elect to have a closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region in which the facility that is closing is located.

E. Applicants may use the planned closure rate adjustment to allow for:

(1) a property payment for a new facility;

(2) an addition to an existing facility; or

(3) as an operating payment rate adjustment.

F. A facility receiving a planned closure rate adjustment is eligible for any other rate adjustments under this Attachment.

G. Upon the request of a facility, the Department may delay the implementation of a closure rate adjustment to offset the cost of a non-Medicaid related facility closure rate adjustment approved by the Department pursuant to Minnesota Department of Health laws. This non-Medicaid related facility closure rate adjustment is a 50 percent rate increase to pay relocation costs or other costs related to facility closure.

SECTION 19.030 **Facility serving exclusively the physically handicapped.** Nursing facilities that serve physically handicapped individuals and which have an average length of stay of less than one year are limited to 140% of the other-operating-cost limit for hospital attached nursing facilities. Other facilities serving physically handicapped individuals but whose average length of stay is not less than one year have a limit of 105 percent of the appropriate hospital attached limit.

SECTION 19.035 **Hospital-attached nursing facilities.** A hospital-attached nursing facility shall use the same cost allocation principles and methods used in the reports filed for the Medicare program.

A hospital-attached nursing facility is a facility which meets the criteria in items A, B, or C.

A. A nursing facility recognized by the Medicare Program to be a hospital-based nursing facility for purposes of being subject to higher cost limits accorded hospital-attached nursing facilities under the Medicare Program is a hospital-attached nursing facility.

B. A nursing facility which, prior to June 30, 1983, was classified as a hospital-attached nursing facility under Minnesota Rules, and which has applied for hospital-based nursing facility status under the Medicare program during the reporting year or the nine-month period following the nursing facility's reporting year, is considered a hospital-attached nursing facility for the rate year following the reporting year or the nine-month period in which the facility made its Medicare application.

(1) The nursing facility must file its cost report or an amended cost report for that reporting year before the following rate year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare Program's hospital-based nursing facility status been granted to the nursing facility.

(2) If the nursing facility is denied hospital-based nursing facility status under the Medicare Program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility pursuant to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility.

C. The surviving nursing facility of a nonprofit or community operated hospital-attached nursing facility which suspended operation of the hospital is considered, at the option of the facility, a hospital-attached nursing facility for five subsequent rate years. In the fourth year the facility will receive 60 percent of the difference between the hospital-attached limit and the freestanding nursing facility limit, and in the fifth year the facility will receive 30 percent of the difference.

D. For rate years beginning on or after July 1, 1995, a nursing facility is considered a hospital-attached nursing facility for purposes of setting payment rates under this attachment if it meets the above requirements, and: (1) the hospital and nursing facility are physically attached or connected by a tunnel or skyway; or (2) the nursing facility was recognized by the Medicare Program as hospital attached as of January 1, 1995 and this status has been maintained continuously.

SECTION 19.040 **Receivership.**

A. The Department in consultation with the Department of Health may establish a receivership fee that exceeds a nursing facility payment rate when the Commissioner of Health or the Commissioner of Human Services determines a nursing facility is subject to the receivership provisions. In establishing the receivership fee payment, the Commissioner must reduce the receiver's requested receivership fee by amounts that the Commissioner determines are included in the nursing facility's payment rate and that can be used to cover part or all of the receivership fee. Amounts that can be used to reduce the receivership fee shall be determined by reallocating facility staff or costs that were formerly paid by the nursing facility before the receivership and are no longer required to be paid. The amounts may include any efficiency incentive, allowance, and other amounts not specifically required to be paid for expenditures of the nursing facility. If the receivership fee cannot be covered by amounts in the nursing facility's payment rate, a receivership fee payment shall be set according to subitems (1) and (2) and payment shall be according to subitems (3) through (5).

(1) The receivership fee per diem is determined by dividing the annual receivership fee by the nursing facility's resident days from the most recent cost report for which the Department has established a payment rate or the estimated resident days in the

projected receivership fee period.

(2) The receivership fee per diem shall be added to the nursing facility's payment rate.

(3) Notification of the payment rate increase must meet the requirements for the notice to private paying residents.

(4) The payment rate in item C for a nursing facility shall be effective the first day of the month following the receiver's compliance with the notice conditions.

(5) The Department may elect to make a lump sum payment of a portion of the receivership fee to the receiver or managing agent. In this case, the Department and the receiver or the managing agent shall agree to a repayment plan.

B. Upon receiving a recommendation from the Commissioner of Health for a review of rates, the Commissioner shall grant an adjustment to the nursing facility's payment rate. The Commissioner shall review the recommendation of the Commissioner of Health, together with the nursing facility's cost report to determine whether or not the deficiency or need can be corrected or met by reallocating nursing facility staff, costs, revenues, or other resources including any investments, efficiency incentives, or allowances. If the Commissioner determines that the deficiency cannot be corrected or the need cannot be met, the Commissioner shall determine the payment rate adjustment by dividing the additional annual costs established during the Commissioner's review by the nursing facility's actual resident days from the most recent desk-audited cost report.

C. If the Department has established a receivership fee per diem for a nursing facility in receivership under item A or a payment rate adjustment under item B, the Department must deduct these receivership payments according to subitems (1) to (3).

(1) The total receivership fee payments shall be the receivership per diem plus the payment rate adjustment multiplied by the number of resident days for the period of the receivership. If actual resident days for the receivership period are not made available within two weeks of the Department's written request, the Department shall compute the resident days by prorating the facility's resident days based on the number of calendar days from each portion of the nursing facility's reporting years covered by the receivership period.

(2) The amount determined in item A must be divided by the nursing facility's resident days for the reporting year in which the receivership period ends.

(3) The per diem amount in item B shall be subtracted from the nursing facility's operating cost payment rate for the rate year following the reporting year in which the receivership period ends. This provision applies whether or not there is a sale or transfer of the nursing facility, unless the provision of item G apply.

D. The Commissioner of Health may request the Commissioner to reestablish the receivership fee payment when the original terms of the receivership fee payment have significantly changed with regard to the cost or duration of the receivership agreement. The Commissioner, in consultation with the Commissioner of Health, may reestablish the receivership fee payment when the Commissioner determines the cost or duration of the receivership agreement has significantly changed. The provisions of developing a receivership fee payment apply to the reestablishment process.

E. The Commissioner of Health shall recommend to the Commissioner a review of the rates for a nursing home or boarding care home that participates in the Medical Assistance Program that is in voluntary or involuntary receivership, and that has needs or deficiencies documented by the Department of Health. If the Commissioner of Health determines that a review of the rate is needed, the Commissioner shall provide the Commissioner of Human Services with: (1) a copy of the order or determination that cites the deficiency or need; and (2) the Commissioner's recommendation for additional staff and additional annual hours by type or employee and additional consultants, services, supplies, equipment, or repairs necessary to satisfy the need or deficiency.

F. Downsizing and Closing nursing facilities. If the nursing facility is subject to a downsizing to closure process during the period of receivership, the Commissioner may reestablish the nursing facility's payment rate. The payment rate shall be established based on the nursing facility's budgeted operating costs, the receivership property related costs, and the management fee costs for the receivership period divided by the facility's estimated resident days for the same period. The Commissioner of Health and the Commissioner shall make every effort to first facilitate the transfer of private paying residents to alternate service sites prior to the effective date of the payment rate. The cost limits and the case mix provisions in the rate setting system shall not apply during the portion of the receivership period over which the nursing facility downsizes to closure.

G. Sale or transfer of a nursing facility in receivership after closure.

(1) Upon the subsequent sale or transfer of a nursing facility in receivership, the Commissioner must recover any amounts paid through payment rate adjustments under item F which exceed the normal cost of operating the nursing facility. Examples of costs in excess of the normal cost of operating the nursing facility include the managing agent's fee, directly identifiable costs of the managing agent, bonuses paid to employees for their continued employment during the downsizing to closure of the nursing facility, prereceivership expenditures paid by the receiver, additional professional services such as accountants, psychologists, and dietitians, and other similar costs incurred by the receiver to complete receivership. The buyer or transferee shall repay this amount to the Commissioner within 60 days after the Commissioner notifies the buyer or transferee of the obligation to repay. The buyer or transferee must also repay the private-pay resident the amount the private-pay resident paid through payment rate adjustment.

(2) If a nursing facility with payment rates subject to item F, subitem (1) is later sold while the nursing facility is in receivership, the payment rates in effect prior to the receivership shall be the new owner's payment rates. Those payment rates shall continue to be in effect until the rate year following the reporting period ending on September 30 for the new owner. The reporting period shall, whenever possible, be at least five consecutive months. If the reporting period is less than five months but more than three months, the nursing facility's resident days for the last two months of the reporting period must be annualized over the reporting period for the purpose of computing the payment rate for the rate year following the reporting period.

Upon the subsequent sale or transfer of the nursing facility, the department may recover amounts paid through payment rate adjustments under this section. The buyer or transferee will repay this amount to the department within 60 days after the department notifies the buyer or transferee of the obligation to repay. The buyer or transferee must also repay the private-pay resident the amount the private-pay resident paid through payment rate adjustment.

SECTION 19.050 **Medicare upper payment limit rate adjustment.** In the event that the aggregate payment rates determined under this plan exceed the Medicare upper payment limit established at 42 CFR § 447.272, a rate adjustment will be determined as follows:

A. Aggregate the payment rates determined under this plan.

B. Determine the Medicare upper payment limit in accordance with 42 CFR §447.272.

C. Subtract item A from item B.

D. If item C exceeds zero, divide the amount in item C by total statewide nursing facility resident days during the rate year in which item C exceeds zero.

E. Subtract item D from the rate otherwise determined under this plan.

SECTION 19.060 **Employee scholarship costs and training in English as a second language (ESL).**

A. For the rate years beginning July 1, 2001 and July 1, 2002, the Department will provide to each nursing facility reimbursed pursuant to Sections 1.000 to 20.000 or pursuant to Section 21.000 a scholarship per diem of .25 to the total operating payment rate to be used for employee scholarships and to provide job-related training in ESL.

B. For rate years beginning on or after July 1, 2003, the .25 scholarship per diem is removed from the total operating payment rate, and the scholarship per diem is based on actual costs.

SECTION 19.080 **Disproportionate share nursing facility payment adjustment.** On May 31 of each year, the Department shall pay a disproportionate share nursing facility payment adjustment after noon on that day to a nursing home that, as of January 1 of the previous year, was county-owned and operated, with the county named as licensee by the Commissioner of Health, had over 40 beds and had medical assistance occupancy in excess of 50 percent during the reporting year ending September 30, 1991. The adjustment shall be an amount equal to $16 per calendar day multiplied by the number of beds licensed in the facility as of September 30, 1991. These payments are in addition to the total payment rate established under Section 17.000.

SECTION 19.090 **Disaster-related provisions.**

A. Notwithstanding a provision to the contrary, a facility may receive payments for expenses specifically incurred due to a disaster. Payments will be based on actual documented costs for the period during which the costs were incurred, and will be paid as an add-on to the facility's payment rate, or as a lump sum payment. The actual costs paid will be reported on the next annual cost report as non-allowable costs, in order to avoid duplicate payment. Costs submitted for payments will be subject to review and approval by the Department. The Department's decision is final and not subject to appeal. Costs not paid in this manner may be

claims on the subsequent cost report for inclusion in the facility's payment rate.

B. For transfers of less than 60 days, the rates continue to apply for evacuated facilities and residents are not counted as admissions to facilities that admit them. The resident days related to the placement of such residents who continued to be billed under an evacuated facility's provider number are not counted in the cost report submitted to calculate rates, and the additional expenditures are considered non-allowable costs for facilities that admit victims.

C. For transfers of 60 days or more, a formal discharge/admission process must be completed, so that the resident becomes a resident of the receiving facility.

D. When a person is admitted to a facility from the community, the resident assessment requirement in Section 14.010 is waived. If the resident has resided in the facility for 60 days or more, the facility must comply with Section 14.010 as soon as possible.

SECTION 19.100 **Bed layaway and delicensure.**

A. For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under Sections 1.000 through 20.000 that places beds on layaway will, for purposes of application of the downsizing incentive in Section 15.040, item G, and calculation of the rental per diem, have the beds given the same effect as if the beds had been delicensed so long as they remain on layaway. At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under Section 15.110. The property payment rate increase is effective the first day of the month following the month in which the layaway of the beds becomes effective under state law.

B. For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary in Section 21.000, a nursing facility reimbursed under Section 21.000 that places beds on layaway is, for so long as the beds remain on layaway, allowed to:

(1) Aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system in Section 21.000;

(2) Retain or change the facility's single bed election for use in calculating capacity days under Section 15.110; and

(3) Establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

C. The Department will increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and subitems (1), (2), and (3). If a facility reimbursed under Section 21.000 completes a moratorium exception project after its base year, the base year property rate is the moratorium project property rate. The base year rate is inflated by the factors in Section 21.060, items C through F. The property payment rate increase is effective the first day of the month following the month in which the layaway of the beds becomes effective.

D. If a nursing facility removes a bed from layaway status in accordance with state law, the Department will establish capacity days based on the number of licensed and certified beds in the facility not on layaway and will reduce the nursing facility's property payment rate in accordance with item B.

E. For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under Section 21.000, a nursing facility reimbursed under that section, with delicensed beds after July 1, 2000, by giving notice of the delicensure to the Department of Health according to the notice requirements in state law, is allowed to:

(1) Aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) Retain or change the facility's single bed election for use in calculating capacity days under Section 15.110; and

(3) Establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The Department will increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and subitems (1), (2), and (3). If a facility reimbursed under Section 21.000 completes a moratorium exception project after its base year, the base year property rate is the moratorium project property rate. The base year rate is inflated by the factors in Section 21.060, items C through F. The property payment rate increase is effective the first day of the month following the month in which the delicensure of

the beds becomes effective.

F. For nursing facilities reimbursed pursuant to Sections 1.000 to 20.000 or Section 21.000, any beds placed on layaway are not included in calculating facility occupancy as it pertains to leave days.

G. For nursing facilities reimbursed pursuant to Sections 1.000 to 20.000 or Section 21.000, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

H. A nursing facility receiving a rate adjustment as a result of this section must not increase nursing facility rates for private pay residents until it notifies the residents, or the persons responsible for payment of the increase, in writing 30 days before the increase takes effect. No notice is required if a rate increase reflects a necessary change in a resident's level of care.

I. A facility that does not utilize the space made available as a result of bed layaway or delicensure under this section to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this section reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

SECTION 20.000 ANCILLARY SERVICES

SECTION 20.010 **Setting payment and monitoring use of therapy services.** At the option of the nursing facility, payment for ancillary materials and services otherwise covered under the plan may be made to either the nursing facility in the operating cost per diem, to the vendor of ancillary services, or to the nursing facility outside of the operating cost per diem. The avoidance of double payments shall be made through audits and adjustments to the nursing facility's annual cost report. The Department will also determine if the materials and services are cost effective and as would be incurred by a prudent and cost-conscious buyer. Therapy services provided to a recipient must be medically necessary and appropriate to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician cannot provide adequate medical necessity justification, the Department may recover or disallow the payment for the services and may require prior authorization for therapy services or may impose administrative sanctions to limit the provider participation in the medical assistance program.

SECTION 20.020 **Certification that treatment is appropriate.** The therapist who provides or supervises the provision of therapy services must certify in writing that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient every 30 days. The Department shall utilize a peer review program to make recommendations regarding the medical necessity of services provided.

~~SECTION 20.030 **Separate billings for therapy services.** Nursing facilities shall be subject to the following requirements:~~

~~A. The invoice must include the provider number of the nursing facility where the medical assistance recipient resides regardless of the service setting.~~

~~B. Nursing facilities that are related by ownership, control, affiliation, or employment status to the vendor of therapy services shall report the revenues received during the reporting year for therapy services provided to residents of the nursing facility. For rate years beginning on or after July 1, 1988, the Department shall offset the revenues received during the reporting year for therapy services provided to the total payment rate of the nursing facility by dividing the amount of offset by the nursing facility's actual resident days. Except as specified in items D and F below, the amount of offset shall be the revenue in excess of 108 percent of the cost removed from the cost report resulting from the requirement of the Department to ensure the avoidance of double payments. In establishing a new base period for the purpose of setting operating cost payment rate limits and rates, the revenues offset shall not be included.~~

~~C. For rate years beginning on or after July 1, 1987, nursing facilities shall limit charges in total to vendors of therapy services for renting space, equipment, or obtaining other services during the rate year to 108 percent of the annualized cost removed from the reporting year cost report resulting from the requirement to ensure the avoidance of double payments. If the arrangement for therapy services is changed so that a nursing facility is subject to this paragraph instead of item B, the cost that is used to determine rent must be adjusted to exclude the annualized costs for therapy services that are not provided in the rate year. The maximum charges to the vendors shall be based on the Department's determination of annualized cost and may be subsequently adjusted upon resolution of appeals. After June 30, 1993, property costs excluded from the nursing facility's property related payment rate shall be determined based on the ratio of service area square footage times the nursing facility's property related payment rate. Nursing facilities that are reimbursed according to Section 21.000 and are located in a county participating in the state's §1115 prepaid medical assistance waiver program are exempt from the maximum therapy rent revenue provisions of this item.~~

~~D. The Department shall require reporting of all revenues relating to the provision of therapy services and shall establish a therapy cost to revenue ratio for the reporting year ending in 1986. For subsequent reporting years, the ratio may increase five percentage points in total until a new base year is established. Increases in excess of five percentage points may be allowed if adequate justification is provided to and accepted by the Department. Unless an exception is allowed the amount of offset in item B is the greater of the amount determined in item B or the amount of offset that is imputed based on one minus the lesser of: (1) the actual reporting year ratio; or (2) the base reporting year ratio increased by five percentage points, multiplied by the revenues.~~

~~E. A new reporting year base for determining the cost to revenue ratio may be established.~~

~~F. If the arrangement for therapy services is changed so that a nursing facility is subject to the provisions of item B instead of item C, an average cost to revenue ratio based on the ratios of nursing facilities that are subject to the provisions of item B shall be imputed for item D.~~

~~G. This section does not allow unrelated nursing facilities to reorganize related organization therapy services and provide services among themselves to avoid offsetting revenues. Nursing facilities that are found to be in violation of this provision shall be subject for treble civil damages on that portion of the fee in excess of that allowed. Damages awarded must include three times the excess payments together with cost and disbursements including reasonable attorney's fees or their equivalent.~~

~~H. Section 20.030 does not apply to nursing facilities that are reimbursed according to Section 21.000 and are located in a county participating in the State's §1115a prepaid medical assistance waiver program~~.

SECTION 21.000 CONTRACTUAL ALTERNATIVE PAYMENT RATES AFTER AUGUST 1, 1995

SECTION 21.010 **Contractual alternative payment rate.** A nursing facility may apply to be paid a contractual alternative payment rate instead of the cost-based payment rate established under Sections 1.000 to 20.000. A nursing facility selected to receive an alternative payment rate must enter into a contract with the state. Payment rates and procedures for facilities selected to receive an alternative payment rate are determined and governed by this section and

by the terms of the contract. Different contract terms for different nursing facilities may be negotiated.

SECTION 21.020 **Requests for proposals.**

A. At least twice annually the Department will publish a request for proposals to provide nursing facility services according to this section. All proposals must be responded to in a timely manner.

B. Any proposal may be rejected if, in the judgment of the Department, a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota.

SECTION 21.030 **Proposal requirements.**

A. In issuing the request for proposals, the Department may develop reasonable requirements which, in the judgment of the Department, are necessary to protect residents or ensure that the contractual alternative payment demonstration project furthers the interest of the state of Minnesota.

B. The request for proposals may include, but need not be limited to, the following:

(1) A requirement that a nursing facility make reasonable efforts to maximize Medicare payments on behalf of eligible residents;

(2) Requirements designed to prevent inappropriate or illegal discrimination against residents enrolled in the medical assistance program as compared to private paying residents;

(3) Requirements designed to ensure that admissions to a nursing facility are appropriate and that reasonable efforts are made to place residents in home and community-based settings when appropriate;

(4) A requirement to agree to participate in a project to develop data collection systems and outcome-based standards for managed care contracting for long-term care services;

(5) A requirement that contractors agree to maintain Medicare cost reports and to submit them to the Department upon request or at times specified by the Department;

(6) A requirement for demonstrated willingness and ability to develop and maintain data collection and retrieval systems to be used in measuring outcomes; and

(7) A requirement to provide all information and assurances required by the terms and conditions of federal approval.

SECTION 21.040 **Selection process.**

A. The number of proposals that can be adequately supported with available state resources, as determined by the Department, may be accepted.

B. The Department may accept proposals from a single nursing facility or from a group of facilities through a managing entity.

C. The Department will seek to ensure that nursing facilities under contract are located in all geographic areas of the state.

D. In addition to the information and assurances contained in the submitted proposals, the Department may consider the following in determining whether to accept or deny a proposal:

(1) The facility's history of compliance with federal and state laws and rules, except that a facility deemed by the Department to be in substantial compliance with federal and state laws and rules is eligible to respond to a request for proposal. A facility's compliance history is not the sole determining factor in situations where the facility has been sold and the new owners have submitted a proposal;

(2) Whether the facility has a record of excessive licensure fines or sanctions or fraudulent cost reports;

(3) The facility's financial history and solvency; and

(4) Other factors identified by the Department that it deems relevant to a determination that a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota.

E. If the Department rejects the proposal of a nursing facility, it will provide written notice to the facility of the reason for the rejection, including the factors and evidence upon which the rejection was based.

SECTION 21.050 **Duration and termination of contracts.**

A. Contracts with nursing facilities may be executed beginning November 1, 1995.

B. All contracts entered into under this section are for a term of one year.

C. Either party may terminate a contract at any time without cause by providing 90 calendar days advance written notice to the other party. The decision to terminate a contract is not appealable.

D. The contract will be renegotiated for additional one-year terms, unless either party provides written notice of termination. The provisions of the contract will be renegotiated annually by the parties before the expiration date of the contract.

E. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

F. If a nursing facility fails to comply with the terms of a contract, the Department will provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance.

G. If the facility fails to come into compliance or to remain in compliance, the Department may terminate the contract. If a contract is terminated, the contract payment remains in effect for the remainder of the rate year in which the contract was terminated, but in all other respects the provisions of this section do not apply to that facility effective as of the date the contract is terminated.

H. The contract must contain a provision governing the transition back to the cost-based reimbursement system established under Sections 1.000 to 20.000.

SECTION 21.060 ~~**Alternative**~~ Alternate **rates for nursing facilities.**

For nursing facilities that have their payment rates determined pursuant to this section rather than pursuant to Sections 1.000 to 20.000, a rate must be established under this section

as follows:

A. The nursing facility must enter into a written contract with the Department;

B. A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the same payment rate as established for the facility under Sections 1.000 to 20.000;

C. A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment as provided in items D and E, and an adjustment to include the cost of any increase in Minnesota Department of Health licensing fees for the facility taking effect on or after July 1, 2001.

D. The index for the inflation adjustment must be based on the change in the

Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the rate year.

E. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

F. For the rate years beginning July 1, 1999 ~~and~~ ,July 1, 2000, July 1, 2001, and July 1, 2002, items C, D, and E apply only to the property related payment rate, except that adjustments to include the cost of any increase in Minnesota Department of Health licensing fees taking effect on or after July 1, 2001, shall be provided. In determining the amount of the property related payment rate adjustment under items C, D and E, the Department must determine the proportion of the nursing facility's rates that are property related based on the facility's most recent cost report.

SECTION 21.065 **Facility rate increases beginning July 1, 1999.** For the rate year beginning July 1, 1999, a nursing facility's case mix rate is divided into the following components: compensation operating rate, non-compensation operating rate, property rate and other-components rate. The compensation and non-compensation operating rates are increased by the percentages in Section 11.049, item B, subitem (1), respectively. The property related payment rate is increased as described in Section 21.060, item F. The other-components rate

is not increased from the June 30, 1999 rate.

A. A nursing facility in Becker county licensed for 102 beds on September 30, 1998 receives the following increases:

(1) $1.30 in its case mix class A payment rate;

(2) $1.33 in its case mix class B payment rate;

(3) $1.36 in its case mix class C payment rate;

(4) $1.39 in its case mix class D payment rate:

(5) $1.42 in its case mix class E and F payment rate;

(6) $1.45 in its case mix class G payment rate;

(7) $1.49 in its case mix class H payment rate;

(8) $1.51 in its case mix class I payment rate;

(9) $1.54 in its case mix class J payment rate; and

(10) $1.59 in its case mix class K payment rate;

B. A nursing facility in Chisago county licensed for 101 beds on September 30, 1998 receives an increase of $3.67 in each case mix payment rate:

C. A nursing facility in Canby, licensed for 75 beds will have its property-related per diem rate increased by $1.21. This increase will be recognized in the facility's contract payment rate under this section.

D. A nursing facility in Golden Valley with all its beds licensed to provide residential rehabilitative services to physically handicapped young adults has the payment rate computed according to this section increased by $14.83; and

E. A county-owned 130-bed nursing facility in Park Rapids has its per diem contract payment rate increased by $1.02 for costs related to compliance with comparable worth requirements.

SECTION 21.066 **Facility rate increases beginning July 1, 2000.** For the rate year beginning July 1, 2000, nursing facilities with an average operating rate as described in items A through F receive the rate increases indicated. "Average operating rate" means the average of the eleven (A-K) case mix operating rates. The increases are added following the determination under Section 11.050 of the payment rate for the rate year beginning July 1, 2000, and will be included in the nursing facilities' total payment rates for the purposes of determining future rates under this attachment to the State plan.

A. Nursing facilities with an average operating rate of $110.769 receive an operating cost per diem increase of 5.9 percent, provided that the facilities delicense, decertify, or place on layaway status, if that status is otherwise permitted by law, 70 beds.

B. Nursing facilities with an average operating rate of $79.107 receive an increase of $1.54 in each case mix payment rate.

C. Nursing facilities with an average operating rate of $80.267 receive an increase in their case mix resident class A payment of $3.78, and an increase in their payment rate for all other case mix classes of that amount multiplied by the class weight for that case mix class established in Section 13.030.

D. Nursing facilities with an average operating rate of $94.987 receive an increase of $2.03 in each case mix payment rate to be used for employee wage and benefit enhancements.

E. Nursing facilities with an average operating rate of $82.369 have their operating cost per diem increased by the following amounts:

(1) case mix class A, $1.16;

(2) case mix class B, $1.50;

(3) case mix class C, $1.89;

(4) case mix class D, $2.26;

(5) case mix class E, $2.63;

(6) case mix class F, $2.65;

(7) case mix class G, $2.96;

(8) case mix class H, $3.55;

(9) case mix class I, $3.76;

(10) case mix class J, $4.08; and

(11) case mix class K, $4.76.

F. Nursing facilities with an average operating rate of $95.974 that decertified 22 beds in calendar year 1999 have their property-related per diem payment rate increased by $1.59.

SECTION 21.067 **Facility rate increases beginning July 1, 2001.**

A. For the rate year beginning July 1, 2001, the Department will provide an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on June 30, 2001 include the adjustment in Section 11.070.

B. For rate years beginning on or after July 1, 2001 and for admissions occurring on or after July 1, 2001, the total payment rate for the first 90 paid days after admission is:

(1) for the first 30 paid days, the rate is 120 percent of the facility's medical assistance rate for each case mix class; and

(2) for the next 60 paid days after the first 30 paid days, the rate is 110 percent of the facility's medical assistance rate for each case mix class.

C. For rate years beginning on or after July 1, 2001 and for admissions occurring on or after July 1, 2001, beginning with the 91st paid day after admission, the payment rate is the rate otherwise determined under this Section.

D. For the rate year beginning July 1, 2001, the Department will adjust the operating payment rates for low-rate facilities. For each case mix level, if the amount computed under item A is less than the amount of the operating payment rate target level for July 1, 2001, below, the Department will make available the lesser of the amount of the operating payment rate target level for July 1, 2001, or an increase of ten percent over the rate in effect on June 30, 2001, as an adjustment to the operating payment rate. For the purposes of this item, facilities are considered metro if they are located in Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott, or Washington counties; or in the cities of Moorhead or Brekenridge; or in St. Louis county, north of Toivola and south of Cook; or in Itasca county, east of a north south line two miles west of Grand Rapids.

Operating Payment Rate Target Level for July 1, 2001

Case Mix Classification	Metro	Nonmetro
A	$76.00	$68.13
B	$83.40	$74.46
C	$91.67	$81.63
D	$99.51	$88.04
E	$107.46	$94.87
F	$107.96	$95.29
G	$114.67	$100.98
H	$126.99	$111.31
I	$131.34	$115.06
J	$138.34	$120.85
K	$152.26	$133.10

E. For the rate year beginning July 1, 2001, two-thirds of the money resulting from the rate adjustment under item A and one-half of the money resulting from the rate adjustment under items B through D must be used to increase the wages and benefits and pay associated costs of all employees except management fees, the administrator, and central office staff.

(1) Money received by a facility resulting from the rate adjustments under items A through D must be used only for wage and benefit increases implemented on or after July 1, 2001.